

**BRIDGING RENTAL ASSISTANCE PROGRAM  
APPLICATION & TENANT CERTIFICATION**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ GENDER: Male ☐ Female ☐

CURRENT ADDRESS (INCLUDE PROGRAM NAME IF LIVING IN COMMUNITY RESIDENTIAL SETTING):  
\_\_\_\_\_

CURRENT PHONE: \_\_\_\_\_

PRIOR LIVING SITUATION: \_\_\_\_\_

1. Is applicant an AMHI Consent Decree Class Member? YES ☐ NO ☐

\*

(A Consent Decree Class Member is someone who was hospitalized at AMHI on or after January 1, 1988.)

2. Does applicant meet Eligibility For Care for Community Support Services?

(As defined in Section 17 of the MaineCare Benefits Manual)

YES ☐ NO ☐\*

*\*If you answered 'no' to questions #1 & #2 you are not eligible for assistance under BRAP*

3a. Does applicant have a representative payee or guardian? YES ☐ NO ☐

*If 'yes' then name, address, phone # of payee/guardian: \_\_\_\_\_*

\_\_\_\_\_

3b. Does applicant wish us to copy all correspondence with another person other than a representative payee or guardian?

YES ☐ NO ☐

*If 'yes' then name, address, phone # of person: \_\_\_\_\_*

\_\_\_\_\_

4. Is the applicant receiving currently or in the process of being (re-)instated for SSI and/or SSDI?

YES ☐ NO ☐

5. Is applicant currently on a wait list for federally subsidized housing?

YES ☐ NO ☐

a. If 'No' why? \_\_\_\_\_

b. What is the current status on waiting list or date of application?

\_\_\_\_\_

c. Housing Authority or Agency that holds the application?

\_\_\_\_\_

ATTACH VERIFICATION FROM THE HOUSING AUTHORITY OR MANAGEMENT COMPANY WHERE YOU  
APPLIED FOR SUBSIDIZED HOUSING AND/OR SECTION 8\*\*\*



**6. Please indicate and ATTACH VERIFICATION for all that apply ( #1-#4):**

- #1      Applicant is leaving a State Institution (Riverview or Dorothea Dix); or a private psychiatric hospital bed; or has been discharged in the last 6 months from any of these institutions.
- #2      Applicant is homeless as defined by the US Department of Housing & Urban Development:
- ☐      is sleeping in places not meant for human habitation, such as cars, parks, sidewalks, and abandoned or condemned buildings; or are sleeping in emergency shelters. This may include persons who ordinarily sleep in one of the above places but are spending a short time (30 consecutive days or less) in a hospital or other institution.
- ☐      is graduating from transitional housing specifically for homeless persons;
- ☐      is being evicted within the week from private dwelling units and  
(1) no subsequent residences have been identified; and  
(2) they lack the resources and support networks needed to obtain access to housing;
- ☐      is a person being discharged within the week from institutions in which they have been residents for more than 30 consecutive days; and  
(1) no subsequent residences have been identified; and  
(2) they lack the resources and support networks needed to obtain access to housing.
- #3      Applicant is living in substandard housing in the community. A unit is substandard if the unit: Is dilapidated; Does not have operable indoor plumbing; Should, but does not, have a useable flush toilet inside the unit for the exclusive use of the family; Should, but does not, have a useable bathtub or shower inside the unit for the exclusive use of the family; Does not have electricity, or has inadequate or unsafe electrical service; Does not have a safe or adequate source of heat; Should, but does not have a kitchen; and/or Has been declared unfit for habitation by an agency or unit of government.
- #4      Eligible people who are moving from community residential programs and other behavioral health facilities, to more independent living arrangements.

7. Family composition: The apartment will be occupied by the Applicant and members of the household listed below: failure to report all household members or failure to report a change in household members is a crime. This may result in your application being denied and/or your assistance being terminated and/or legal action against you.

Name	Relationship	DOB	SSN

8. Household financial information: List Monthly Income for the Applicant and any household member residing in household. Include and identify all sources of income (i.e. SSI/SSDI, General Assistance, employment, stipends, endowments, etc.)

	Source	Monthly Total
a. Applicant		
b. Household mbr1		
c. Household mbr2		
d. Household mbr3		
TOTAL		\$

\*\*\* ATTACH VERIFICATION FOR ALL INCOME\*\*\*

9. Has the applicant ever received BRAP or other housing assistance in the past?

YES ☐ NO ☐

e. If yes, where:  

f. Reason for leaving BRAP or other assistance program:  

#### Non-Discrimination Notice

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to DHHS' ADA Compliance/EEO Coordinators, 11 State House Station – 221 State Street, Augusta, Maine 04333, 207-287-4289 (V), 207-287-3488 (V), 1-800-606-0215 (TTY). Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.



Applicants are not required to engage in services as a condition of acceptance into the Bridging Rental Assistance Program.

## 10. CERTIFICATIONS:

\_\_\_\_\_ **Initials** Any previous BRAP recipient may re-apply for subsidy, as long as he or she is eligible and in good standing with any housing subsidy program administered by DHHS (Bridging Rental Assistance Program &/or Shelter Plus Care). Applicants who owe any DHHS administered housing subsidy program for back rent, damages, security, etc., may be considered for readmission providing that one of the following minimum criterion has been met:

- ▣ 50% of account balance must be paid before move in. The remaining balance must be paid over a term not to exceed 12 months with a documented payment plan; or
  - ▣ Establishment of a Representative Payee and a documented payment plan not to exceed 12 months; or
  - ▣ Charges have been adjudicated through the BRAP Appeals or DHHS Grievance Process.
- Failure to meet at least one of the above criterion will result in program in-eligibility and termination of rental assistance.

\_\_\_\_\_ **Initials** Section 8 compliance: I understand that one of the eligibility criterion for BRAP is that I must maintain an active application for federally assisted housing during my entire tenure with BRAP (not to exceed 24 months), with a local Public Housing Authority or Administrator. If a wait list is closed, I understand that I am obligated to get on the list at the earliest opening date. I understand that if I do not comply with this and other requirements detailed in the Tenant Responsibility Agreement, I may be immediately terminated from BRAP.

\_\_\_\_\_ **Initials** Release of Information: I/We agree to complete the necessary release(s) of information which will allow \_\_\_\_\_(Name of LAA) to obtain, verify, and document information pertaining to initial and ongoing eligibility for rental assistance provided under this program.

\_\_\_\_\_ **Initials** Release of information: I/we agree to have any and all correspondence relating to initial and ongoing eligibility for rental assistance copied to my guardian and/or representative payee and/or other designated person as identified in question 3a and/or 3b.

\_\_\_\_\_ **Initials** Tenant's Certification: I/We certify that the information contained in this application is true and complete to the best of my/our knowledge and belief. Failure to furnish true, accurate, and complete information, now or in the future, will result in one or more of the following: termination from program, eviction, formal investigation, legal action. Intentionally submitting false or incomplete information, including but not limited to submitting false household income and/or composition, is a crime.

\_\_\_\_\_ **Initials** If you were homeless prior to enrolling in BRAP: The Bridging Rental Assistance Program is a participant in the statewide Homeless Management Information System (HMIS). Participation in the BRAP program means your information and the information of your household members will be submitted to a secure database so that Maine can generate mandated federal reports about homelessness.

\_\_\_\_\_  
Print Applicant Name

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name-Other Adult Mbr

\_\_\_\_\_  
Other Adult Mbr Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name-Other Adult Mbr

\_\_\_\_\_  
Other Adult Mbr Signature

\_\_\_\_\_  
Date



## CONSENT FOR RELEASE OF INFORMATION

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

I authorize Local Administering Agency, \_\_\_\_\_ to release to and obtain information and/or records regarding my HOUSING by and between the following entities:

Shalom House, Inc.  
106 Gilman Street  
P.O. Box 560  
Portland, ME 04112  
and  
State of Maine  
Department of Health and Human Services

Shalom House, Inc. is the Central Administering Agency for the statewide Bridging Rental Assistance Program (BRAP).

I give my permission to the Local Administering Agency listed above to provide and share information regarding my housing needs and tenant history. I understand this information is necessary for the purposes of:

- Determining BRAP initial and ongoing eligibility
- Coordinating housing resources
- Continuing BRAP assistance
- Coordinating BRAP assistance throughout the state

This Consent to Release Information will automatically expire in one year, on \_\_\_\_\_.

I am the individual to whom the information and records apply or that person's legal guardian.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Eligibility Verification

1. I hereby affirm the above-enclosed information concerning current housing situation, current address, and eligibility criteria are true and accurate for this client as indicated above; and
2. I verify the Applicant meets the Eligibility For Care for Community Support Services as defined in Section 17 of the MaineCare Benefits Manual or is already enrolled in PNMI services:

CHECK APPROPRIATE BOX (ES) and include verification:

- i. ☐ Applicant is already enrolled in Adult Mental Health Services funded Community Support (Section 17) and/or PNMI services (Section 97)—verification of enrollment with APS HealthCare or DHHS attached; **OR**
- ii. ☐ No APS HealthCare or DHHS Adult Mental Health Enrollment form is currently on file. I have attached a completed BRAP Enrollment Form to provide a mental health diagnosis or have attached such a signed qualifying diagnosis my agency deems appropriate to document eligibility for services under Section 17 as may be approved by APS HealthCare and/or DHHS to the BRAP Enrollment Form; **OR**
- iii. ☐ Applicant has been determined otherwise eligible by one of the following: DHHS Adult Mental Health Team Leader; Director of Housing Resource Development; Utilization Review Nurse; Medical Director.

Name of DHHS Designated Representative and Credentials \_\_\_\_\_  
\_\_\_\_\_

Referring Agency: \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

=====

### LAA OFFICE USE ONLY TO DETERMINE APPLICANT ELIGIBILITY

☐ ELIGIBLE      ☐ NOT ELIGIBLE

Reason(s) for ineligibility:

- ☐ No appropriate documentation of Eligibility for DHHS Mental Health Services
- ☐ No Priority Rating
- ☐ Income Ineligible
- ☐ Poor Standing with DHHS Subsidy Program
- ☐ Other (explain briefly): \_\_\_\_\_

Local Administrative Agency: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Office of Adult Mental Health Services

**BRAP ENROLLMENT FORM**

To be completed for persons not already *Enrolled* in Section 17/97 Services

**Part I. Client Information**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Part II. Specific Eligibility Requirements:** Check all appropriate spaces that apply.

A client meets the specific eligibility requirements for covered services under Section 17 if:

- ☐ A. The person is a Class Member; **(OR)**
- ☐ B. The person is age eighteen (18) or older or is an emancipated minor:

-----AND-----

- ☐ 1. has a primary diagnosis on Axis I or Axis II of the multi-axial assessment system of the current version of the Diagnostic and Statistical Manual of Mental Disorders, except that the following diagnoses may not be primary diagnoses for purposes of this eligibility requirement:
  - a. Delirium, dementia, amnesic, and other cognitive disorders;
  - b. Mental disorders due to a general medical condition, including neurological conditions and brain injuries;
  - c. Substance abuse or dependence;
  - d. Mental retardation;
  - e. Adjustment disorders;
  - f. V-codes; (or)
  - g. Antisocial personality disorders

-----AND-----

- ☐ 2. Has a score of 50 or below on the Global Assessment of Functioning (GAF) scale as determined by a professional licensed to assign a clinical diagnosis, **AND**
- ☐ a. At least one of the following consequences resulting from signs and symptoms of the psychiatric diagnosis:
  - ☐ i. has become homeless or at risk of losing his or her current residence (a person is homeless when he or she is without shelter or at serious risk of being without shelter, that is, when he or she lives in housing that is substandard, unaffordable, or life-threatening);
  - ☐ ii. is causing repeated disturbances in the community because of poor judgment or bizarre, intrusive, or ineffective behavior;
  - ☐ iii. is at great risk of arrest because of behavior which results from his or her psychiatric diagnoses, or is presently incarcerated because of such behavior;
  - ☐ iv. presents a clear risk of harming self or others without Community Support Services;
  - ☐ v. manifests great difficulty in caring for self, posing a threat to his or her life or limb, without Community Support Services; (or)
  - ☐ vi. would deteriorate clinically to a point of needing immediate medical or psychiatric hospitalization in the absence of prompt community support services;

**Part III. DSM Diagnostic Classification:** Diagnosis must be given by a qualified professional who is licensed to make a mental health diagnosis.

AXIS I Classification # \_\_\_\_\_ Classification described \_\_\_\_\_ Date given: \_\_\_\_\_

AXIS II Classification # \_\_\_\_\_ Classification described \_\_\_\_\_ Date given: \_\_\_\_\_

AXIS III Classification # \_\_\_\_\_ Classification described \_\_\_\_\_ Date given: \_\_\_\_\_

AXIS IV Classification # \_\_\_\_\_ Classification described \_\_\_\_\_ Date given: \_\_\_\_\_

AXIS V (GAF Score) \_\_\_\_\_

**Part IV: Signatures and Certifications:**

I certify that the information contained on this form is true and complete to the best of my knowledge and belief. Intentionally submitting false or incomplete information is a crime.

\_\_\_\_\_  
Clinician Signature and credentials

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name and credentials

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**For LAA Internal Use Only:**

My agency deems the above certification or the attached documentation as necessary and appropriate to meet eligibility standards for Section 17 Services.

\_\_\_\_\_  
Signature